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Secretary Leslie Kirwan, Executive Office of Administration and Finance
Co-Chair, Special Commission on the Health Care Payment System
State House, Room 373
Boston MA, 02133

Commissioner Sarah Iselin, Division of Health Care Finance and Policy
Co-Chair, Special Commission on the Health Care Payment System
2 Boylston Street
Boston, MA 02116

Re: Comments on Proposed Recommendations
Health Care Payment System

Dear Secretary Kirwan and Commissioner Iselin:

I am an Internist at Massachusetts General Hospital and an Assistant Professor of Medicine at Harvard.[1] In the course of my hospital-based practice of primary care since 1992 and of my private integrative medicine practice[2] over the past six years, I have increasingly been impressed by the need to broaden the scope of services offered by the conventional medical system in order to achieve more effective and less expensive care of individual patients. I believe that your efforts to modify the payment system are opportune and could lead to both a lessening of costs and the delivery of more effective care.

Cost Savings Goals and Pitfalls

Cost savings in our health care system can be achieved both

1) through decreasing the number and perhaps the cost of conventional procedures and prescriptions authorized by medical practitioners, and

2) through shifting care when medically appropriate toward services designed to help patients make lifestyle and nutritional change and become healthier, and

3) through inclusion of a broader array of modalities in our medical tool kit, including complementary and alternative medicine (CAM) therapies that have been shown by research and practice to have significant benefits for certain conditions.

I believe that the new payment system needs to be crafted very carefully in order to avoid barriers to the second and third such goals and even to promote access by patients to these services. If the modifications you propose limit progress to the first goal, a great opportunity both to decrease cost and to improve care will be lost.

Nutrition, Behavioral Change and Disease

As an example, there were some 23.5 million diabetics in the United States in 2007 according to the NIH and there are about 57 million pre-diabetics according to the CDC. Ample research has been done to understand the relationship between diet and type 2 (adult onset) diabetes and the relationship of obesity to type 2 diabetes. Yet conventional care by and large has essentially devolved into dispensing and managing drugs and a certain amount of finger-wagging on the nutrition front. I have had very positive experience in focusing on behavioral change, including psychotherapy and providing nutritional education and access to appropriate meals for diabetics.

While drugs can manage rather erratically the blood sugars of diabetics, proper nutrition if adopted as a lifestyle change can improve blood sugars, reduce medication and prevent many of the adverse outcomes in patients such as circulatory problems, gangrene and amputation, and also can reduce both outpatient and inpatient medical services. I have seen patients over a very short period of time, of weeks and not months, with an appropriate diet, move their sugars down into the normal range. Normal patients do not cost the health care system much money. I have seen similar improvements in patients with coronary artery disease, arthritis, inflammatory bowel disease and quite a number of other ailments.

My point is that an aspect of health that currently is not handled very effectively, if at all, in the conventional medical system could be addressed at a great savings to the system, both as prevention and as treatment. This is low-hanging fruit ripe for the picking and should not be ignored.

Some conventional practitioners will counter that patients just are not willing or able to make changes in behavior and diet. While this may be true for a relatively small percentage of our most fragile patients, most patients with nutritional education, support and access to healthier meals and lifestyles are capable of making enough change to make

a difference. Of course, this presupposes that some level of effort and financial resources are directed at behavioral change rather than just at the next expensive drug or surgical intervention. Changes in the health care payment system could provide the financial resources for this very effective effort.

Behavioral economists have quite a bit to say about diet change. Cass R. Sunstein and Richard H. Thaler, in their recent book *Nudge*, conclude that, "Eating turns out to be one of the most mindless activities we do. Many of us simply eat whatever is put in front of us." They suggest many strategies geared toward helping people eat more consciously and make better choices. The medical system has the potential to contribute to this effort, but only if that contribution is compensated. Currently, any limited efforts by the medical system to encourage nutritional change are either poorly compensated or not compensated at all, and are largely ineffective.

Other Modalities

While I have focused here on nutrition, there are other modalities that also can be of benefit to both patients and the financial viability of the health care system. Many of these other modalities have been subjected to rigorous testing and are clearly evidence-based. Others may require more research, which should be done. We need to foster a greater curiosity among conventional practitioners, researchers, educators and institutions about modalities that have not traditionally been within their training and practice. An most important of all in the current context, we need to assure in any new health care payment system that appropriate use of such modalities is not discouraged.

As has been clearly documented by researchers such as my Harvard colleague, David Eisenberg, M.D., patients are flocking in droves to some of these modalities, often without telling their conventional practitioners. The problem is that this kind of self-referral does not necessarily get patients to the right resources or qualified practitioners. We in conventional medicine would do well to acknowledge that some if not many of these modalities have very practical benefits for patients and that we as advisers in the health care of patients need to be knowledgeable and participate in selecting and collaborating with practitioners in these other modalities. To date, we have even a relatively poor track record of coordinating care within the services that conventional medicine now offers.

Specific Suggestions

At this point in following your deliberations, I believe that there are three areas of particular concern on which I would encourage you to focus.

> Costs recognized in determining global payments. Costs recognized in calculating global payments should include services offered by more innovative providers

such as nutrition education and certain CAM therapies. These services have a cost, albeit generally much lower than the cost of conventional medical services, drugs and devices, and need to be factored into the equation. Of course, the overall cost of services for more innovative providers will need to compete with the costs of providers offering only the services currently offered in conventional medicine. My experience leads me to believe that appropriate use of this broader range of services will reduce costs and promote a healthier patient population.

Permit providers to offer non-covered services paid out of pocket by patients. To the extent that certain services are not included in global payments, providers should have the option of charging patients for those services. Differing providers may choose to offer such "ancillary" services on a sliding scale, may seek partial support from institutions or philanthropy for such services, or may offer them for a fixed fee. If providers are not permitted to render such services for compensation, the division between the medical system and other health care providers will widen, fewer patients will have the opportunity to benefit from these services, and the medical system will not benefit from the cost savings that can be achieved through appropriate use of these services.

I would add that, particularly in the case of behavioral change issue but also in other areas of health, investment by patients through co-pays or payment for services on a fee-for-service basis tends to foster a sense of personal investment. Some of my poorest patients pay out of pocket for services offered through my private integrative medicine practice, even if on a sliding scale or over a long period of time, and their progress is enhanced by this investment in themselves. Eliminating co-pays or patient charges for services does not necessarily increase access or use of such services or promote their effectiveness.

ACO governance and global payment distribution. Accountable Care Organizations (ACOs) hopefully will take many differing forms, some larger, some smaller, some dominated by hospitals and health care systems, some controlled by providers with contractual relationships with hospitals. To the extent that current conventional specialties and institutions govern ACOs and determine the distribution of global payments, the broadening of services by providers, especially at the primary care level, may well be restricted. The significant interest of the Commonwealth in reducing costs and promoting health needs to be monitored and enforced in the distribution of global payments within ACOs and in the governance of ACOs in general.

I encourage you to design a new health care payment system that encourages practitioners and institutions to broaden the scope of their participation in the health of patients. This will have the double benefit of improving health and of saving health care dollars. If we stay mired in the conventional medical tool kit alone, with drug and

surgical interventions as the primary strings to our bows, costs will continue to increase and our population will continue to become less healthy in a vicious downward spiral toward the impoverishment of our general health and our health care system.

Respectfully yours,

Kathryn Hayward, M.D.

cc: Commission Members

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[1] While I have been associated with Harvard, Massachusetts General Hospital and affiliated institutes and practices for many years, the views expressed above are my own and not necessarily those of any institution, practice or other group.

[2] Integrative Medicine brings together the best in:
- •Conventional Medicine
- •Complementary and Alternative Therapies
- •Energy Therapies
- •Mind/Body Medicine
- •Fitness
- •Nutrition